TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Killeen Injury Clinic

Respondent Name
Castlepoint National Insurance

MFDR Tracking Number
M4-13-2002

Carrier's Austin Representative
Box Number 17

MFDR Date Received
April 11, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Most of the dates of service that were submitted for MDR were already paid except DOS 07/06/12, 10/09/12, and 10/16/12. …The services that are not yet paid are for individual psychotherapy. Per the first denial EOBs, the claims were denied due to precertification/authorization exceeded. Their denial reason is incorrect; the services were provided within the preauthorization time frame."

Amount in Dispute: $2,855.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the Dates of Service identified above and has determined that additional payments are owed per the attached Explanation of Benefits."

Response Submitted by: Tower Group Companies, 4425 W. Airport Freeway, Ste 230, Irving, TX 75062

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 7, 2012 through November 28, 2012	Mental Health Therapy and Physical Therapy	$2,855.00	$258.32

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization/notification absent
   - 198 – Precertification/authorization exceeded
   - W1 – Workers compensation state fee schedule adjustment
   - 39 – Services denied at the time authorization/pre-certification was requested
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

Issues

1. What services remain in dispute?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor submitted a position statement dated April 5, 2013 that contained disputed services for dates of service ranging from June 7, 2012 through November 28, 2012 for a total of $2,855.00. The requestor supplemented their original position statement on December 5, 2013 citing payments were made for some of the services in dispute. The Carrier in their response submitted evidence of payment. Review of that submitted information finds that:

   - Payment was made for the following dates of service listed on DWC 60 requesting MFDR;
     - May 1, 2013, DOS - July 13, 2012 – (90806 $129.16. 90889 $90.00) total payment $219.16
     - April 30, 2013, DOS – July 17, 2012 – (90806 $129.16. 90889 $90.00) total payment $219.16
     - April 30, 2013, DOS – July 24, 2012 – (90806 $129.16. 90889 $90.00) total payment $219.16
     - May 1, 2013, DOS – October 2, 2012 – (97110 $200.00) total payment $188.60
     - May 1, 2013, DOS – October 3, 2012 – (97110 $200.00) total payment $188.60
     - May 1, 2013, DOS – October 5, 2012 – (97110 $200.00) total payment $188.60
     - May 1, 2013, DOS – October 10, 2102 – (97110 $200.00) total payment $188.60
     - April 30, 2013, DOS – October 16, 2012 – (97110 $200.00) total payment $188.60
     - April 30, 2013, DOS – October 31, 2012 – (90882 $150.00) total payment $150.00
     - April 30, 2013, DOS – November 28, 2013 – (90882 $150.00) total payment $150.00
   - The following dates of service were on the DWC 60 and remain in dispute:
     - DOS – June 7, 2012, - 90806 - Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient and 90889 - Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers
     - DOS – July 6, 2012, - 90806 - Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient and 90889 - Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers

- DOS – October 9, 2012, - 90806 - Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient and 90889 - Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers
- DOS – October 16, 2012, - 90806 - Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient and 90889 - Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers

2. The insurance carrier denied the remaining disputed services with claim adjustment reason code s 197 – "Precertification/authorization/notification absent", 198 – "Precertification/authorization exceeded", 97 – "The benefit for this service in included in the payment/allowance for another service/procedure that has already been adjudicated". Review of the submitted documentation finds;

    a. Notification of Determination from Coventry dated June 27, 2012, "Request received date – June 22, 2012." Certified Quantity – Individual Psychotherapy 0, **Non-certified** 4.

    b. Outcome of review of requested treatment dated September 6, 2012, "Certified Quantity, 6 mental health therapy, Start Date 09/04/2012 End date 11/04/12

    Based on the above, the dates of service June 7, 2012 and July 6, 2012 were not authorized. The carrier's denial is supported.

    However, the Division found insufficient evidence to support the denials for dates of service October 9, 2012 and October 16, 2012. These services will be reviewed per applicable rules and fee guidelines.

3. 28 Texas Administrative Code 134.203 (c) states,

    To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

    (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

The maximum allowable reimbursement is calculated as follows;

- Procedure code 90806, service date October 9, 2012, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.86 multiplied by the geographic practice cost index (GPCI) for work of 1 is 1.86. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 0.912 is 0.43776. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.809 is 0.05663. The sum of 2.35439 is multiplied by the Division conversion factor of $54.86 for a MAR of $129.16.
- Procedure code 90889, service date October 9, 2012, has a status indicator of B, which denotes a bundled code. Payments for these services are always bundled into payment for other services to which they are incident.
- Procedure code 90806, service date October 16, 2012, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.86 multiplied by the geographic

practice cost index (GPCI) for work of 1 is 1.86. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 0.912 is 0.43776. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.809 is 0.05663. The sum of 2.35439 is multiplied by the Division conversion factor of $54.86 for a MAR of $129.16.

- Procedure code 90889, service date October 16, 2012, has a status indicator of B, which denotes a bundled code. Payments for these services are always bundled into payment for other services to which they are incident.

4. The total allowable reimbursement for the services in dispute is $258.32. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $258.32. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $258.32.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $258.32 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		October 8, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.